Alignment Health Plan®

2027 SUMMARY OF BENEFITS

Alignment Health ONE + Walgreens 001 (HMO-POS)
Alignment Health Smart 010 (HMO-POS)

El Paso
Hudspeth

This is a summary of drug and health services benefits covered by Alignment Health Plan for January 1, 2027 - December 31, 2027.

AlignmentHealthPlan.com

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PREMIUMS AND BENEFITS	Alignment Health ONE + Walgreens 001 (HMO-POS) El Paso and Hudspeth counties	Alignment Health Smart 010 (HMO-POS) El Paso and Hudspeth counties
Monthly Plan Premium • Part C & Part D	**$0.00**	**$0.00**
Part B Premium Rebate	Not covered	**$153.90**
Deductible	**$0.00**	**$0.00**
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**$2,950.00**	**$6,450.00**
Inpatient Hospital [1] In-Network	**$0.00** per day, days 1-2 **$120.00** per day, days 3-7 **$0.00** per day, days 8-90 (unlimited days per admission)	**$375.00** per day, days 1-6 **$0.00** per day, days 7-90 (unlimited days per admission)
Out-of-Network	**$100.00** per day, days 1-2 **$250.00** per day, days 3-7 **$0.00** per day, days 8-90 (unlimited days per admission)	**$450.00** per day, days 1-6 **$0.00** per day, days 7-90 (unlimited days per admission)
Outpatient Hospital [1] In-Network • Hospital Services	**$0.00**	**$200.00**
• Observation Services	**$0.00**	**$0.00**
Out-of-Network	Not covered	Not covered
Ambulatory Surgical Center [1] In-Network	**$0.00**	**$50.00**
Out-of-Network	Not covered	Not covered
Doctor Visits In-Network • Primary	**$0.00**	**$0.00**
• Specialists	**$15.00**	**$35.00**
Out-of-Network • Primary	Not covered	Not covered

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• Specialists	**$15.00**	Not covered
Preventive Care (e.g., flu vaccine, diabetic screenings) In-Network	**$0.00**	**$0.00**
Out-of-Network	Not covered	Not covered
Emergency Care In and Out-of-Network	**$100.00** (waived if admitted within 48 hours)	**$130.00** (waived if admitted within 48 hours)
Urgently Needed Services **In and Out-of-Network**	**$0.00**	**$20.00** (not waived if admitted)
Outpatient Diagnostic [1] In-Network • Procedures, tests, lab services	**$0.00**	**$0.00**
• X-Ray	**$0.00**	**$0.00**
• Diagnostic	**$0.00**	**$0.00**
• Therapeutic radiology services (such as radiation treatment for cancer)	**20%** coinsurance	**20%** coinsurance
Out-of-Network	Not covered	Not covered
Hearing Services In-Network • Routine hearing exam	**$0.00** Medicare-covered benefits and 1 exam/fitting/ evaluation every year Additional coverage with the FLEX Allowance, see FLEX Allowance below	**$0.00** Medicare-covered benefits and 1 exam/fitting/ evaluation every year
• Hearing aids	**$195.00** - **$1,750.00** copay per hearing aid, 2 hearing	Not covered

PREMIUMS AND BENEFITS	Alignment Health ONE + Walgreens 001 (HMO-POS) El Paso and Hudspeth counties	Alignment Health Smart 010 (HMO-POS) El Paso and Hudspeth counties
	aids every year Additional coverage with the FLEX Allowance, see FLEX Allowance below	
Out-of-Network • Routine hearing exam	Not covered	Not covered
• Hearing aids	Not covered	Not covered
Dental Services [1] In-Network Diagnostic and preventive:	**$0.00** for Medicare-covered services	**$0.00** for Medicare-covered services
• Exam	**$0.00** for 1 every six months	**$10.00**
• Cleaning	**$0.00** for 1 every six months	**$20.00**
• Fluoride treatment	**$0.00** for 1 every six months	**$10.00**
• X-Ray	**$0.00** for 1 every three years Additional coverage with the FLEX Allowance, see FLEX Allowance below	**$30.00**
Comprehensive: • Restorative • Endodontics • Periodontics • Removable Prosthodontics • Fixed Prosthodontics • Oral and Maxillofacial Surgery	**$0.00** **$0.00** **$0.00** **$0.00** **$0.00** **$0.00** **$2,500.00** coverage limit every year for preventive and comprehensive combined Additional coverage with the FLEX Allowance, see FLEX Allowance below	Not covered
Out-of-Network Diagnostic and preventive:	Not covered	Not covered
Comprehensive:	Not covered	Not covered

PREMIUMS AND BENEFITS	Alignment Health ONE + Walgreens 001 (HMO-POS) El Paso and Hudspeth counties	Alignment Health Smart 010 (HMO-POS) El Paso and Hudspeth counties
Vision Services In-Network		
• Routine exam	**$0.00** Medicare-covered eye exams/1 routine eye exam every year Additional coverage with the FLEX Allowance, see FLEX Allowance below	**$0.00** Medicare-covered eye exams/1 routine eye exam every year
• Eyewear	**$200.00** coverage limit for glasses/contacts every year Additional coverage with the FLEX Allowance, see FLEX Allowance below	**$100.00** coverage limit for glasses/contacts every two years
Out-of-Network		
• Routine exam	Not covered	Not covered
• Eyewear	Not covered	Not covered
Mental Health Services [1] In-Network		
• Inpatient hospital	**$120.00** per day, days 1-10 **$0.00** per day, days 11-90 **$0.00** for 40 additional day limit **$0.00** for 60 "lifetime reserve days"	**$120.00** per day, days 1-10 **$0.00** per day, days 11-90 **$0.00** for 40 additional day limit **$0.00** for 60 "lifetime reserve days"
• Mental health specialty (individual and group)	**$10.00**	**$20.00**
• Psychiatric services (individual and group)	**$20.00**	**$20.00**
Out-of-Network		
• Inpatient hospital	Not covered	Not covered
• Mental health specialty (individual and group)	Not covered	Not covered

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• Psychiatric services (individual and group)	Not covered	Not covered
Skilled Nursing Facility [1]		
In-Network	**$20.00** per day, days 1-20 **$100.00** per day, days 21-100 (no prior hospital stay required)	**$10.00** per day, days 1-20 **$100.00** per day, days 21-100 (no prior hospital stay required)
Out-of-Network	Not covered	Not covered
Physical and Speech Therapy [1]		
In-Network	**$0.00**	**$0.00**
Out-of-Network	Not covered	Not covered
Ground and Air Ambulance Services [1]		
In-Network	**$200.00** (waived if admitted)	**$200.00** (waived if admitted)
Out-of-Network	Not covered	Not covered
Transportation [1]		
In-Network	**$0.00** 34 one-way trips to plan approved locations every year (within a 30-mile radius)	Not covered
Out-of-Network	Not covered	Not covered
Medicare Part B Drugs [1]		
In-Network	**0%** - **20%** coinsurance	**0%** - **20%** coinsurance
Out-of-Network	Not covered	Not covered

Outpatient Prescription Drugs		
ALIGNMENT HEALTH ONE + WALGREENS 001 (HMO-POS) El Paso and Hudspeth counties		
Part D Deductible	**$0.00**	
Part D Out of Pocket Threshold	**$2,400.00**	
Initial Coverage	Retail 30-day supply	Mail-order 100-day supply
Tier 1 (Preferred Generic Drugs):	**$0.00**	**$0.00**
Tier 2 (Generic Drugs):	**$0.00**	**$0.00**
Tier 3 (Preferred Brand Drugs):	**$45.00**	**$135.00**
Tier 4 (Non-Preferred Drugs):	**32%** coinsurance	**32%** coinsurance
Tier 5 (Specialty Tier):	**33%** coinsurance	Not covered
Tier 6 (Select Care Drugs):	**$5.00**	**$0.00**

ALIGNMENT HEALTH SMART 010 (HMO-POS) El Paso and Hudspeth counties		
Part D Deductible	**$700.00** for Tier 4 and Tier 5	
Part D Out of Pocket Threshold	**$2,400.00**	
Initial Coverage	Retail 30-day supply	Mail-order 100-day supply
Tier 1 (Preferred Generic Drugs):	**$0.00**	**$0.00**
Tier 2 (Generic Drugs):	**$0.00**	**$0.00**
Tier 3 (Preferred Brand Drugs):	**$45.00**	**$135.00**
Tier 4 (Non-Preferred Drugs):	**40%** coinsurance	**40%** coinsurance
Tier 5 (Specialty Tier):	**25%** coinsurance	Not covered
Tier 6 (Select Care Drugs):	**$5.00**	**$0.00**

UNDERSTANDING YOUR DRUG COVERAGE	Alignment Health ONE + Walgreens 001 (HMO-POS) El Paso and Hudspeth counties	Alignment Health Smart 010 (HMO-POS) El Paso and Hudspeth counties
Cost-Sharing	May vary depending on the pharmacy you choose and the payment stage of the Part D benefit you are in. If you reside in a long-term care facility, you will pay the same cost-sharing amount for a 31-day supply as you would for a 30-day supply at an in-network retail pharmacy.	
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach **$2,400.00**, you pay **$0.00** for plan-covered Part D drugs for the remainder of the year. For plans with excluded drug coverage under our enhanced benefit, you pay the same copayment as you did in the Initial Coverage Stage.	
Bonus Drugs	Additional coverage of certain drugs that are not typically covered under Part D such as generic Viagra, and select drugs within the categories of prescription vitamins, hair loss, and cough and cold products. For a complete list of covered drugs and coverage details, please refer to the Drug List (Formulary).	
Insulin	You won't pay more than **$35.00** for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it's on.	
Vaccines	Our plan covers most Part D vaccines at no cost to you.	

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN	Alignment Health ONE + Walgreens 001 (HMO-POS) El Paso and Hudspeth counties	Alignment Health Smart 010 (HMO-POS) El Paso and Hudspeth counties
ACCESS On-Demand Concierge Card Provides access to OTC benefits and Healthy Rewards	Included	Included
Complete Package		
Monthly Premium	Not covered	**$64.90**
Dental Coverage		
• Diagnostic	Not covered	**0%** coinsurance
• Restorative		**50%** coinsurance
• Endodontics		**50%** coinsurance
• Periodontics		**0%-50%** coinsurance
• Removable Prosthodontics		**50%** coinsurance
• Fixed Prosthodontics		**50%** coinsurance
• Oral and Maxillofacial Surgery		**50%** coinsurance **$1,500.00** coverage limit per year
Additional Coverage		
• Hearing Aid Coverage	Not covered	**$195.00** - **$1,750.00** copay per hearing aid, 2 hearing aids every year
• Personalized Emergency Response System (PERS)	Not covered	**$0.00**
• Transportation	Not covered	24 one-way trips every year to plan approved locations (within 30-mile radius)
• Worldwide Emergency Coverage	Not covered	Additional **$75,000.00** coverage limit every year
Fitness (membership(s) at participating fitness centers)	**$0.00**	**$0.00**
Flex Allowance Additional coverage for services related to vision, dental, hearing, routine acupuncture, routine chiropractic, and routine podiatry	**$200.00** maximum spending every year	Not covered

EXTRA BENEFITS YOU GET WITH ALIGNMENT HEALTH PLAN	Alignment Health ONE + Walgreens 001 (HMO-POS) El Paso and Hudspeth counties	Alignment Health Smart 010 (HMO-POS) El Paso and Hudspeth counties
Personalized Health Risk Screening	**$75.00** 1 screening every two years	Not covered
Chiropractic Services [1] In-Network	**$0.00** Medicare-covered Routine visits with FLEX Allowance	**$10.00** Medicare-covered
Out-of-Network	Not covered	Not covered
Acupuncture [1] In-Network	**$0.00** Medicare-covered Routine visits with FLEX Allowance	**$0.00** Medicare-covered
Out-of-Network	Not covered	Not covered
Podiatry Services [1] In-Network	**$5.00** Medicare-covered Routine visits with FLEX Allowance	**$5.00** Medicare-covered
Out-of-Network	Not covered	Not covered
Over-the-Counter (OTC)	**$20.00** spending allowance every month (no rollover)	Not covered
Telehealth In-Network	**$0.00** for primary care provider services **$20.00** for mental health specialty and psychiatric services	**$0.00** for primary care provider services **$20.00** for mental health specialty and psychiatric services
Worldwide Emergency/ Urgent Care	**$0.00** **$50,000.00** coverage limit every year	**$0.00** **$25,000.00** coverage limit every year
Durable Medical Equipment (DME) [1] In-Network	**0%** coinsurance for items **$450.00** or less **20%** coinsurance for items **$450.01** or more	**20%** coinsurance

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Out-of-Network	Not covered	Not covered
In-Home Support Services [1]	**$0.00** 48 hours every year **OR** Support for Caregivers (member must choose in advance)	Not covered
Support for Caregivers of Enrollee [1]	**$0.00** Up to **$300.00** reimbursement every year **OR** In-Home Support Services (member must choose in advance)	Not covered
Re-admission and Chronic Meals	**$0.00** for 28 meals over 14 days, twice per year	Not covered
Extra Benefits for those with Qualifying Condition (SSBCI) Special supplemental benefits for the chronically ill (SSBCI)-qualifying chronic conditions include congestive heart failure (CHF), chronic lung disorders, dementia, diabetes, and stroke. Other chronic conditions may apply. Medical records will be used to establish the member qualification. The benefits mentioned are a part of a special supplemental program for the chronically ill. Not all members qualify because other eligibility and coverage criteria also apply.		
Essentials Allowance For qualifying members to assist with groceries, utilities, and home safety.	**$30.00** spending allowance every month (no rollover)	Not covered
Pet Services For members who have hospital procedures or emergencies and need pet care while they are away.	**$0.00** 7 boarding days or 14 walks every year	**$0.00** 7 boarding days or 14 walks every year
Pest Control Annual pest eradication for covered pests to ensure the health, welfare, and safety of members.	**$0.00** **$500.00** coverage limit for 1 service every year	**$0.00** **$500.00** coverage limit for 1 service every year

Understanding Your Plan	
Who Can Join?	**You must be enrolled in Medicare Part A and Part B and live in one of the counties listed on the cover of this booklet.**
Alignment Health Plan Members	**1-866-634-2247 (TTY 711)**
Prospective Members	**1-888-979-2247 (TTY 711)**
Hours of Operation	**October 1 – March 31:** Seven days a week from 8:00 a.m. to 8:00 p.m. except Thanksgiving and Christmas Day **April 1 – September 30:** Monday through Friday (except holidays) from 8:00 a.m. to 8:00 p.m.
Website	alignmenthealthplan.com

This plan(s) allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits. To learn more about coverage and costs of Original Medicare, look at the "Medicare & You" handbook. You can view it online at medicare.gov or request a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. This information is not a complete description of benefits. For complete details, including limitations and exclusions, please refer to the Evidence of Coverage (EOC) or call 1-866-634-2247 (TTY 711) 24 hours a day, 7 days a week.

Services notated with a "1" may require prior authorization. Services notated with a "2" may require a referral from your doctor. For more information on the pharmacy-specific copays, please call Alignment Health Plan Member Services Department at the phone number in this document or access your Evidence of Coverage at alignmenthealthplan.com.

This document is also available in other languages and formats.

Alignment Health Plan is an HMO, HMO POS, HMO C-SNP, HMO D-SNP and PPO plan with a Medicare contract and a contract with the California, Nevada, North Carolina, and Texas Medicaid programs. Enrollment in Alignment Health Plan depends on contract renewal. Alignment Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.